What Early Childhood Educators & Caregivers Need to Know About

Fetal Alcohol Syndrome

Our Children
Manitoba's Future

MANITOBA CHILD CARE ASSOCIATION

Manitoba Healthy Child Initiative

Acknowledgements

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Introduction

This manual is intended for early childhood educators and caregivers of children diagnosed with Fetal Alcohol Syndrome (FAS) or other alcohol-related disorders. *For the purposes of this manual, the use of the word "parents" refers to the people who live with the child and are the primary caretakers. This includes foster parents and legal guardians.*

Dr. Julianne Conry, author of "Parenting Children Affected by FAS: A Guide for Daily Living", explains the basic philosophy behind caring for children with FAS/FAE:

> There is no single "right" way to parent a child with FAS/FAE. Each child is unique. Nor do we need to "reinvent the wheel" in devising techniques to teach a child with FAS/FAE. By recognizing each child's particular strengths and weaknesses, it becomes possible to devise ways of teaching and parenting that will allow him/her to be successful. We recognize now that this is a life-long effort and success is measured in small increments. Support for children, their families and communities begins with knowledge and understanding of this invisible disability.

This manual gives you the information you need to help you care for these children. It includes:

- background knowledge of Fetal Alcohol Syndrome and related disorders, including definitions, methods of diagnosis and common characteristics and misconceptions.
- concrete strategies for daily living, including simple ideas that can be used in most early childhood settings and homes.
- suggestions for developing and maintaining a strong, supportive connection between families and child care programs.
- information about the various professionals and agencies that may be involved with these children.

While children with FAS and other alcohol-related disorders represent similar challenges, each child has his or her own individual abilities. Therefore, it is important for you to learn as much as possible about the individual child you will be caring for and how to best support him or her. The preparation you do before the child enters your program or home is very important. Having a positive attitude and focusing on the best interests of the child can help make it a successful experience for everyone.

You may know children who have some of the same characteristics as those diagnosed with FAS. Many of these strategies are general enough to try with other children who have special needs.

Definitions and Facts

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When a pregnant woman consumes alcohol, she does not drink alone. Alcohol is a known teratogen, which means it is a substance that can damage the developing embryo and fetus. The brain and central nervous system of the unborn child are particularly sensitive to alcohol in the mother's body.

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Fetal Alcohol Syndrome (FAS) refers to a variety of physical and mental birth defects that may develop in individuals whose mothers drank alcohol during pregnancy. It is an organic brain disorder characterized by ***central nervous system involvement, growth retardation, and characteristic facial features.***

FAS is a medical diagnosis that can only be made when a child shows signs of abnormalities in each of the three areas and there is known or suspected exposure to alcohol prenatally (in the womb). Other physical defects may include malformation of major organs (e.g. heart, kidneys, liver) and other parts of the body (e.g., muscles, genitals, bones).

FAS is often called a "hidden" or "invisible" disability because its physical characteristics can be subtle and may go unrecognized. Many children affected by alcohol are endearing and affectionate, and these qualities can mask the seriousness of this lifelong neurological disability.

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A diagnosis of FAS is made when there is known, or suspected prenatal exposure to alcohol and the child exhibits three characteristics:

1. **Delayed prenatal and/or postnatal growth**

   The delay must result in height and/or weight below the tenth percentile.

2. **Central nervous system involvement**

   This can result in one or more of the following conditions being observed in the child:

   - head circumference below the third percentile,
   - developmental delay or intellectual disabilities, and/or

- learning disabilities or attention deficit/hyperactivity disorder.

Other less common conditions may also be observed.

3. **Characteristic facial features**

   These include short eye slits, elongated mid-face, long and flattened nose and upper lip, thin upper lip and flattened facial bone structure. These facial features are most noticeable during early childhood. They are sometimes not evident in infancy and may change during adolescence. The fact that the physical characteristics may be less evident in adulthood does not mean the child has "outgrown" FAS. On the other hand, some children may have these characteristic facial features without other symptoms of FAS. In this case, they are not likely to have the syndrome.

Fetal Alcohol Effects (FAE) is a term that has been used to describe an individual with a history of prenatal alcohol exposure, who doesn't display all the physical or behavioral symptoms of FAS. Other terminology is now being used to more accurately reflect the range of disorders caused by prenatal exposure to alcohol. A full description of these diagnostic terms is given in Appendix I.

The term FAS has been used in this document, to refer to the whole range of alcohol-related disorders. In spite of what is often assumed, the terms FAE, partial FAS and others do not describe a "milder" form of FAS. Rather, these children have similar behavioural and cognitive characteristics and the life challenges are much the same.

FAS is the leading known cause of mental retardation and the second most common birth defect.

"Incidence" is a term describing how often a problem occurs annually, based on vital statistics information on live births. Estimates of incidence for FAS range from 1 in 500 births to 1 in 3,000 births. The rate for other alcohol-related effects is estimated at 5 to 10 times higher.

> **Note:** It is recognized that FAS is under-reported due to the difficulty in making diagnoses prospectively (at birth). Before we can be more certain of the incidence of FAS, there needs to be more consistent screening of pregnant women for alcohol and other drug problems, and consistent diagnoses of FAS, and other effects in children of women with alcohol and other drug problems.

Prevalence describes how many people in a population have the problem at a point in time. (This includes all age groups and any new cases.)

Prevalence of FAS and other alcohol-related effects in *high-risk populations* may be as high as 1 in 5.

[redacted] those rates of FAS mean?

- In Manitoba, estimates range as high as 40 cases per 1,000 births. Each child with FAS will require an average of $1.5 million in special care, support, and/or supervision during his/her lifetime. Medical experts have estimated that 240 children with FAS are born annually in Manitoba.
- FAS is a leading known cause of mental handicaps in children, followed by Down's Syndrome and Spina Bifida (approximately 1 in 600 and 1 in 700 respectively).
- FAS is the leading cause of preventable birth defects in developed countries.

[redacted] the key factors that contribute to FAS?

- **We do not know how much alcohol a pregnant woman can safely drink.** However, we do know that the more alcohol a pregnant woman consumes, the greater the range and severity of problems to the developing fetus. Drinking alcohol regularly, or daily, during pregnancy (sometimes called chronic drinking) is considered to be high risk. Drinking alcohol to the point of intoxication on an occasion (sometimes called binge drinking) is also high risk.
- **There is no *"safe"* time period during pregnancy to consume alcohol.** There are critical periods during pregnancy for the development and growth of all body systems. Different FAS features may be linked with the period in which alcohol is heavily consumed. This underlines the benefits of stopping or reducing alcohol use at any point possible during pregnancy.

Common Characteristics

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Some or all of the following may apply to infants with FAS:

- small, scrawny appearance
- often trembling and fussy, may cry a lot
- weak sucking reflex
- little interest in food, feeding difficulties (feeding can take hours)
- difficulties adjusting to solid food because of disinterest and poor appetite
- weak muscle tone
- high susceptibility to illness
- unpredictable sleep patterns/cycles
- high sensitivity to sights, sounds and touch
- failure to thrive (may continue to lose weight longer than normal after delivery)
- delayed developmental milestones (e.g., walking, talking)
- problems with bonding

As these infants get older, you generally see a high orientation to people and the absence of stranger anxiety.

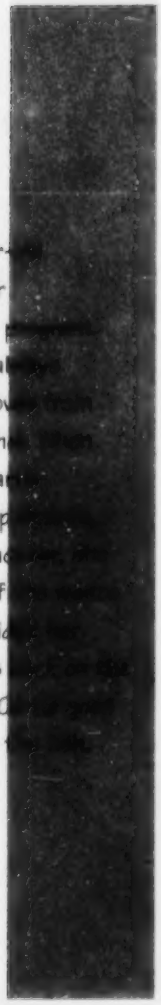
Obviously, infants who are alcohol-affected may be difficult to care for. The challenges around sleeping and feeding can be especially problematic and lead to exhaustion for parents and caregivers.

[redacted] born with FAS. e was not premature, all. He seemed unable nd often cried for long time. He slept for very ds and usually woke up Jason did not seem to eld close. He would give hed yell and stiffen up. en jittery and feeding t — taking as long as d-a-half. He had to be very carefully by health ssionals to ensure that ning weight.

[redacted]

Some or all of the following may apply to preschoolers with FAS:

- short and elf-like in manner and appearance
- continuing feeding and sleep problems
- poor motor coordination, and poor fine and gross motor control
- flitting from one thing to another, exhibiting butterfly-like movements
- more interest in people than objects
- overly friendly and indiscriminate with relationships, may seek out affection



Carrie is a small four year-
with FAS who attends her
neighbourhood pre-school
She is often smiling and a
looks very busy as she mo
one activity area to anoth
clean-up time is called, Ca
continues playing. When ap
by the early childhood edu
runs to another area as if
to be chased. The ECE gui
hands to put some blocks
shelf, but when left alone C
to the fish tank to watch

- expressive language may be delayed or children may be overly talkative (but lack richness of speech, thought or grammar complexity)
- receptive language often delayed; even if children are talkative, they may not understand much of what is said to them
- inability to understand danger, often fearless
- low tolerance for frustration and prone to temper tantrums
- difficulty following directions or doing as told
- short attention span
- easily distracted or hyperactive
- difficulty with changes and transitions, prefer routines

In the preschool years, many new problems can emerge making it increasingly difficult to care for these children. For example, hyperactivity, risk-taking and poor motor skills can often result in these children being exposed to danger or getting into trouble. Furthermore, their friendliness and lack of discrimination in relationships can make them vulnerable to abuse.

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Some or all of the following may apply to school-age children with FAS:

- continuing sleep difficulties
- arithmetic skills more delayed than reading and writing skills
- reading and writing skills usually peak in grades 4 - 6
- poor attention spans and low impulse control become more obvious due to increased demands within the classroom
- difficulty keeping up as school demands become increasingly abstract
- consistent repetition needed to learn a skill or to transfer learning from one situation to another similar one
- "flow through" phenomenon - information is learned, retained for a while, then lost
- in need of constant reminders
- clumsiness related to poor gross motor control
- difficulty with handwriting, dressing, etc. related to poor fine-motor control

- weak social skills and difficulty with relationships (e.g., problems in sharing, taking turns, cooperating, following rules)
- may show a preference for playing with younger children or adults
- poor memory
- problems with time management due to the lack of a sense of time
- lack of understanding consequences of behaviour
- inappropriate demands for bodily contact

Most children with FAS have difficulty with school, because it tends to be a very stimulating and complicated place. The demands of the classroom are often very difficult for them to handle.

Eight year-old Shane has FAS. He seems to be in constant motion, either swinging his arms or legs, or fidgeting in his seat. He much prefers outdoors play to any type of structured activity. However, during this active play, he is quite prone to accidents. Shane experiences difficulties when expected to move from one activity to another or from one place to another. Sometimes he will have a tantrum as a result. He may understand a concept or a word one day, then have no idea what it means the next.

[redacted]ristics

The characteristics listed thus far are the most common ones that pose problems for children with FAS. However, these children also share some positive traits. For example, children with FAS are often:

- friendly, cheerful, loving, affectionate
- caring, kind, concerned, compassionate
- gentle, nurturing towards younger children
- funny, with a great sense of humour
- Persistent and hard working, with a sense of determination
- curious
- creative, artistic, musical
- fair, cooperative
- interested in animals
- interested in activities like gardening and constructing
- highly verbal, good storytellers

Children affected by alcohol, like all children, have a range of positive and negative characteristics. It's very important to have an accurate picture of each child you're working with. Sometimes when having difficulty with certain children, it's hard to notice and remember all their skills and abilities. However, focusing on their positive traits is important for two reasons. First, it helps you to have a positive attitude and recognize the potential in each child. Second, a person's strengths can often be useful tools to help overcome or compensate for negative characteristics.

Common Misconceptions About FAS

The common characteristics of FAS, described in the preceding pages, provides a picture of what to expect from children at various ages. However, it is equally important to discuss the misconceptions or myths about this syndrome. Clarifying these misconceptions will help people better understand the true challenges alcohol-affected individuals face. The following list outlines 10 commonly held misconceptions about FAS and the individuals who have the disease:

1. **MYTH:** *People with FAS have low IQ's.*

   This is sometimes, but not always, the case. FAS refers to brain damage and each individual will have different areas of strengths and weaknesses.

2. **MYTH:** *The behaviour problems associated with FAS are a result of poor parenting or a bad environment.*

   The brain damage leads to information being processed differently. This is what can lead to behaviour problems. Children with FAS can be difficult to raise even in very good environments.

3. **MYTH:** *Children with FAS will outgrow it.*

   FAS does not go away. However, the characteristics and challenges change as the individuals age.

4. **MYTH:** *To admit that people with FAS are brain-damaged is to give up on them.*

   Much more research is needed to help us understand the best ways to support people with FAS. Like other types of brain damage and birth defects, treatments are always being developed to improve and understand the specific neurological impairments.

5. **MYTH:** *This diagnosis will brand them for life.*

   An accurate diagnosis of any disorder identifies the condition, shows us how to treat it and helps us have realistic expectations of the person's abilities.

6. **MYTH:** *People with FAS are not motivated. They always act in irresponsible and inappropriate ways.*

   Their actions don't stem from a lack of motivation. The behaviour is more likely to be caused by memory difficulties, poor problem-solving abilities and a poor understanding of reality.

7. **MYTH:** *One agency can solve any or all of the problems alone.*

   These individuals have a wide variety of needs. Therefore, different types of intervention are necessary and cooperation among agencies and service providers is important.

8. **MYTH:** *The challenges associated with FAS will be solved with existing knowledge.*

   More research is needed before all the challenges can be better understood and addressed.

9. **MYTH:** *FAS will go away on its own.*

   FAS is 100% preventable. However, alcohol is a part of our culture and there are many factors complicating our ability to stop alcohol use during pregnancy.

10. **MYTH:** *The mothers of children with FAS could have easily chosen not to drink during pregnancy. They damaged their children through callousness or indifference.*

    Women who use or abuse alcohol need a lot of support to stop drinking during pregnancy. It's never easy to stop drinking. Pregnancy is an excellent time for women with drinking problems to stop or reduce their use of alcohol. In order to do so, they need respect, understanding and caring assistance.

General Guidelines: Caring for Children Affected by Alcohol

The following guidelines suggest an overall approach to caring for children affected by alcohol.

Observe the children to assess their developmental level and work with them at that level.

Modify your expectations to correspond with their developmental level. Don't assume they will be able to do what their age peers can do.

Identify their strengths, skills and interests and use these to help them learn.

Change the way you interpret their behaviours - If you have the negative perception that they're misbehaving on purpose or because they're lazy or unwilling to follow directions, start to recognize that their behaviour is a result of the brain damage they've suffered.

Provide structure but not control - The difference is that structure is respectful and helps these children understand limits, especially if they participate in designing the structure. Control is more the "because I said so" approach which leads to power struggles.

Establish routines that are developmentally appropriate.

Prepare for transitions which are often difficult for these children who don't like to change what they're doing.

Limit television time and choose non-violent programs.

Model appropriate behaviours so that the children have a visual and concrete example of how something should be done.

Keep instructions simple, concrete and give them one at a time to compensate for the short-term memory difficulties seen in most children with FAS.

Identify behaviours which indicate frustration (e.g., anger or avoidance), and help children find the source of the frustration and ways to deal with it.

Provide training for appropriate expression of feelings using alternatives such as storytelling, art and play.

Teach specific social skills by supervising the children with friends and teaching appropriate responses in context.

Understand their various ways of communicating - They may not be able to tell you how they are feeling so you may need to interpret their behaviour (e.g., increased activity = overstimulation; aggression = frustration, difficulty understanding; withdrawal = feeling tired).

Encourage safe multi-sensory exploration by giving them a wide range of play materials and enough time to explore.

Encourage a multi-sensory, concrete approach to learning because if something is not understood through one of the senses, it may be understood through another. Learning must be hands-on.

Understand their unique sensory needs - The brain damage to children with FAS may cause them to respond differently or have trouble understanding their sensory worlds (e.g., sensitivity to touch, low pain threshold). Consultation with an occupational therapist may be helpful.

Re-evaluate expectations and goals ensuring that the individual's needs are being met. Revise goals without limiting the child's potential.

Expose children to supportive environments where their strengths are recognized, so they can experience success.

Use cultural values, traditions, music and stories to enhance their learning.

Establish partnerships between home, child care program and/or school, and other community groups. This keeps things consistent for the child.

By following these general guidelines, you will be taking a positive approach towards understanding and working with individuals with FAS. The next section deals with specific strategies designed to address individual issues that may affect the children you're involved with.

Specific Strategies

There are many things that early childhood educators, parents and caregivers can do to help support children affected by alcohol. It's not necessary to sacrifice other children's needs to accommodate children with FAS. The modifications suggested for children affected by alcohol will likely be useful for all children, especially those who have behaviour challenges similar to the ones associated with FAS. The recommended changes should produce visible, long-term benefits. The following strategies are divided into three categories:

I. Setting up the Environment

II. Equipment and Activities

III. Interactions and Relationships

[redacted]E ENVIRONMENT:

Structure and Organization: As already discussed, these children often have trouble with distractibility and hyperactivity. In order for them to focus, maintain self-control and understand what is expected of them, they need to be in a setting that provides order and predictability. Therefore, it's important that you try to:

- Have clearly defined activity areas, organized according to specific functions. All items in one area should be related and/or have similar functions.
- Arrange toys in an orderly way. Use buckets or containers to organize items and use pictures on the outside of the containers to show what belongs inside. Pictures on the cupboards or shelves can indicate where each container belongs. A simple method is to use the pictures from the box the item came in.
- Make gradual changes to the environment. When it's necessary to rotate toys or move equipment or furniture, don't do it all at once. Changes can be overwhelming and are best handled slowly, ideally with an adult "walking the child through" the new setting.
- Have clear boundaries/separations between areas. Using dividers or masking tape helps keep one area separate from another. Similarly, play mats or pillows can help define an area.

Remembering who owns a particular object is often difficult for children with FAS unless the item is being held by its owner. Therefore, they may feel free to pick up any item and use it as if it were their own. Also, developmental delays may lead them to respond the way that younger children do when they see something of interest — "I like it, I'll take it". For a child in a group setting who is having trouble understanding ownership, it may be helpful to put a coloured sticker, or s other identifying mark on a child's belongings to act a cue. If the child takes som belonging to someone else, return it, reminding them t belongs to someone else a pointing out that there's n coloured sticker on it.

Visual Cues: Since children affected by alcohol have trouble understanding verbal directions, the setting must include supportive visual cues. These will help the children follow directions and provide the adults with another way to teach a concept. For example:

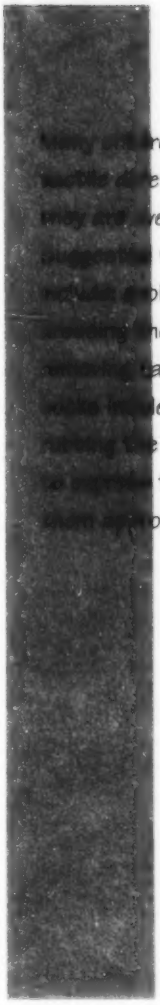
- Consideration should be given to traffic patterns, with visual cues to help children follow a particular path. For example, blue squares in a line on the floor can mark the path to the sink or show children where to line up before gym time.
- Use pictures, along with words, to show the order of the daily routine. If possible, use photos of the child doing the various activities. These can be posted on the wall and/or put on a pocket-sized flip chart with different parts of the day colour-coded. Use a marker (e.g. arrow) to move to the next activity.
- Pictures can also be used to show the steps in a routine. For example, to explain dressing or hand washing, use pictures to represent each step in the sequence.
- Create concrete ways of dealing with abstract concepts. Time is hard to understand, but using something like a large sand timer is helpful, as the child can see the sand flow marking the passage of time.

Low Stimulation: These children often have difficulty with over-stimulation and the processing of information. They may not be able to tune out stimulation, or sensations may be exaggerated for them. Therefore, it is helpful when their environment offers minimal stimulation. For example:

- Keep the visual environment calm by using soothing or neutral colours (e.g., light blue) and keep as much blank space as possible on the walls. Blank wall space is especially important in areas of the room where the child needs to attend most often.
- To reduce the visual stimulation of the play materials in the room, try using blankets to cover equipment that is not being used; turn cupboards so that open shelves face each other or the wall; or use velcro to attach sheets to cover open cupboards.
- Avoid bright lights. Incandescent lighting is recommended. Fluorescent lighting is not a good choice. Outdoors, avoid sunlight reflecting on water or snow - consider allowing the child to wear sunglasses.
- Keep the noise level down. Soft surfaces can help absorb noise. Play classical music, relaxation music or music that incorporates the sounds of nature for a soothing environment.

- Things like lava lamps and wave machines are often useful to help a child focus and remove distractions.
- Directing the child to a small, cozy space can often prevent them from becoming overstimulated. Anything cave-like, such as a small playhouse, a tent or the area under a desk, would work.

Many children with FAS are tactile defensive which means they are overly sensitive to touch. Suggested ways of managing this include: avoiding crowded spaces, dressing the child in loose clothing, removing tags from clothing, turning socks inside out to avoid a seam rubbing the skin and helping them to express their discomfort by giving them appropriate words to use.



Careful Supervision: Children affected by alcohol need close monitoring. Remember, they are usually less able than other children to monitor their own behaviour. This can be addressed through specific environmental considerations. For example:

- Try to set up furniture and equipment so the child is always in your sight.
- Ideally, outdoor play areas should be fenced to avoid the risks associated with wandering.
- Close supervision is necessary on climbers and when dealing with other gross motor equipment. Children with FAS often have a high tolerance for pain and can be fearless when it comes to taking risks.
- Extra care (preferably one-on-one supervision) is needed on field trips or outings. Consider using wristbands to keep a young child close to an adult in public.
- Children with FAS need regular reminders not to go off with strangers, as they are often vulnerable to manipulation. Constant supervision is recommended.
- Dressing children in bright clothing will help make them more visible to drivers. It's a good idea to use reflective tape on clothing if children are outside at night.

A NOTE ON MEALTIME:

A wide range of eating problems is common for children with FAS. Some children eat to excess. Others don't eat enough. Some children eat slowly and many will use food for comfort. Mealtimes are often full of distractions and these children can become easily over-stimulated. Here are some tips for managing this time:

- Allow the child enough time to eat. A child with FAS m[redacted] slowly because of poor [redacted] control. Some children [redacted] a sensitive gag reflex.
- Have a consistent routi[redacted] sequence of events. Thi[redacted] include using the same [redacted] dishes and cutlery for t[redacted] with FAS.
- Ensure the child is in a [redacted] which their feet touch t[redacted] place a stool underfoot.
- Seat the child where th[redacted] least likely to fight with [redacted] child and where distract[redacted] are minimal.
- Having the child serve o[redacted] may avoid difficulties th[redacted] encounter while waiting [redacted] served. It also gives th[redacted] acceptable reason for g[redacted] up during mealtime.

[redacted] AND ACTIVITIES:

Planning Daily Routines and Activities: The importance of a consistent, predictable order to the day cannot be over-emphasized. Think carefully about how each part of the day is planned and presented to these children. For example:

- Follow a consistent daily activity schedule, keeping the same order each day. When changes need to occur, prepare children with FAS ahead of time.
- Make sure each routine of the day also follows the same pattern. For example, the order of things that happen at circle time should remain the same, such as using the same opening and closing song. At home, children should be woken in the same way every morning.
- Alternate active and quiet activities throughout the day. Children with FAS need frequent periods of activity to help them focus for quiet or structured activities.
- Maintain consistency with the people who interact with these children. For example, it's best if the child with FAS eats snacks and lunch each day at the same table with the same children, then has other activities later in the day with those same individuals.
- Design activities to maximize the child's experience of success.

Multi-sensory, Active Learning: Children with FAS need us to be creative in developing ways to help them learn. Adopting a hands-on approach that makes use of all their senses helps them understand new concepts. To help them learn:

- Have many different types of textures available for children to feel.
- Use building projects and three-dimensional art projects.
- Draw or act out stories and use props when telling a story.
- Incorporate music and dance into activities.
- Clay or play-dough should be made available.
- Use computers with software appropriate for their developmental level.
- Try cooking activities that involve counting, measuring, pouring, mixing, etc.
- Initiate role-playing, giving the children an opportunity to practice specific social skills.
- Use pictures and charts to reinforce all spoken information.

Dealing with Hyperactivity: A short attention span and the inability to sit still can be helped with certain types of equipment and activities. For example:

- Use rocking chairs or toys on which the child can spin or swing. This helps children release energy. However, be aware that not all children with FAS can self-regulate and some may need to be guided off before they get dizzy.
- A small, child-safe trampoline for jumping can also be used for energy release.
- A "sit and move" cushion is an inflatable rubber pillow that may provide the extra feedback needed for them to stay relaxed and seated. For a similar effect, use a bean bag chair.
- Use carpet squares at circle time so each child has a boundary for his/her space.
- Have children squeeze playdough or balls to relieve stress.
- Use a listening centre with headphones and audiotapes.
- Limit television and video games if these tend to overstimulate the child.
- Avoid situations requiring long periods of concentration.
- If anger is a problem, consider safe places and ways for children to physically express their anger (e.g., screaming, kicking a ball).
- Avoid rough-and-tumble activities if they cause overstimulation.

Handling Transitions: It takes careful planning to ensure the children can make smooth transitions from one activity to another. Some of the following may be useful:

- Prepare children by giving a warning but keep it concrete. For example, use a sand timer to "show" the passage of time, or tear off the links of a paper chain, one link each minute. When the links are gone it's time to change activities.
- Use musical cues - have a certain song to mark each time the group moves from one activity to another.
- Turning the lights on and off provides a visual cue for the children to attend.
- Be specific when it is time to clean up. Guide them through their tasks one step at a time.
- Have the child with FAS lead the group to the next activity (e.g. carrying the book or prop to circle time).
- Strive for continuity, allowing them to take something from one activity to another.

- [illegible]nsistent expectations [illegible] behaviour. However, [illegible]e that handling forks [illegible]ons may be difficult [illegible]er foods may be needed [illegible]ger period of time.
- Be realistic about the amount of food you expect children to eat.
- Watch for children's response to strong flavours. Some prefer them and others react negatively.
- Similarly, watch for their reactions to food additives and sugar, and reduce these if necessary.
- Some children are extra-sensitive to food temperature or texture. You may need to modify foods if this becomes an issue. For example, if coarse textures are disliked, try finer or pureed foods.

- Offer structured, limited choices and encourage decision-making. Help the child shape his/her environment.
- Develop "hello" and "farewell" rituals for the child with caregivers/parents and staff at the child care facility.

These are major transitions and it is important to handle them well. Parents, caregivers and ECE's should work together to develop consistent routines, sharing ideas on what works best for each child.

[redacted] AND RELATIONSHIPS

Effective Communication: FAS often affects a child's ability to understand language. It's important to consider how directions are given to increase the likelihood that the child will understand them. For example:

- When you start to speak, always use the child's name and make eye contact. They may not realize group instructions are meant for them and may need separate instructions.
- Be very specific as you guide the child - tell the child what you want them *to do* rather than what you want them *not to do.*
- Be very concrete as these children usually take things literally and cannot gauge subtleties or understand figures of speech (e.g. "What's up?"). Avoid using words or phrases that can mean more than one thing.
- Be consistent in the wording used for directions outlining daily routines.
- Be brief, speak slowly, pause between sentences and break directions into steps you can give gradually. Try to help the child remember the next step in a sequence.
- "Why" questions can be especially hard to understand. Rephrase with "What is the reason?" or with "who, what, where, how or show me. . ."
- Help children see the routines of the day by linking one activity to another (e.g. snack is *after* story time).
- Minimize or limit distractions whenever it is especially important for the child to focus or pay attention. For example, the circle-time area may need to be as clutter-free as possible.
- Be expressive, using gestures and hand signals. Exaggerate facial and body language. — When speaking, vary loudness, inflection and tone.

A NOTE ON SPECIALIZED EQUIPMENT:

Some children with FAS need deep pressure sensations (or deep touch) to help them organize and focus. Specialized equipment can provide this type of sensation, suc[redacted] small vibrators or weighte[redacted] to put pressure on the sh[redacted] However, these types of e[redacted] should only be used when recommended and monitor[redacted] an occupational therapist.

- To teach the child about individual space, place your hand on their shoulder and say, "This is how we stand when we are talking."
- Talk about the cues people give regarding their feelings, pointing out facial expressions, tones of voice and body language. This can help the child better interpret social situations as well as show them how to express themselves clearly. They may need help displaying their emotions appropriately. This help may include anger-management strategies.
- Encourage children to speak positively about themselves (e.g. "I can do this!").

Discipline and Guidance: The strategies given here are certainly not unique for children who are alcohol-affected. They reflect the style of guidance recommended for all young children. However, consistency, firmness and a positive approach are especially important as children affected by alcohol may be impulsive and hard to direct.

- Decide which limits are most important, be firm when setting limits, and consistently enforce them.
- Post the rules to be followed using pictures and words.
- Try to step in and redirect misbehaviour before it gets worse.
- Try to ignore negative behaviour whenever appropriate, in order to avoid giving it too much attention and thereby prolonging it.
- To direct the child, give two acceptable choices and if necessary, help the child choose.
- Do not threaten a consequence that cannot be carried out.
- Address misbehaviour without belittling the child. The behaviour may be bad, but the child is not.
- Instead of punishing the child, redirect and support them to behave appropriately.
- Give the child the experience of being the group helper.
- Give specific praise and encouragement, and give it often. (e.g. "good sitting" or "nice listening" rather than "good boy" or "good girl").
- Acknowledge the child positively just for being who they are, and not in relation to any behaviour.
- Discuss cause-and-effect relationships to increase the child's understanding.

E ON
LEEP ROUTINES:

ion to sleep, whether it
or for the night, can
lt one. The following
lp it go more smoothly:

t order of events that
prepare and calm the
r example, choose a
ave a bath or wash up,
eth, choose one soft toy
with, change to pyjamas,
ry on bed, hug good
eave enough time to go
all the steps and be sure
tern is followed by whoever
child to bed.

room dark or use one
. Keep the child's room
hool nap room free of
and materials that
over-stimulating.

- Use relaxing music or the white noise of a fan to block out other noise.
- Be firm about the child needing to stay in bed. If they come out, use the same phrase as you lead them back (e.g. "You stay in this bed now"). In case of night time wanderings, ensure the house is completely safe. Consider locking doors to keep certain areas of the house off-limits or use a safety gate across the child's bedroom door.

Attitudes: The attitudes of the adults involved with a child affected by alcohol are important determinants of the child's success. Generally, the more positive we are about a situation, the more likely it will turn out well. So, when dealing with children affected by alcohol, keep the following points in mind:

- Every child can learn with the right approach.
- These children need structure but not control. Recognize and avoid power struggles.
- Ideally, adults will be calm, gentle and firm.
- Children with FAS have suffered brain damage. They are not willfully misbehaving.
- Nurturing and physical warmth are very important.
- Focus on each child's strengths as much as possible.
- Don't feel sorry for these children. Instead, accept them as individuals.
- Don't take it personally if the child misbehaves.
- Have realistic expectations for the child (not based on generalized assumptions) and try to keep the expectations consistent between home and pre-school.

Special Considerations for Infants/Toddlers

Infants affected by alcohol often have a difficult start. Their first few months can be a very trying time for their caregivers/parents. The babies can be extremely fussy, with frequent crying periods and poor sleep patterns. They are often irritable and generally dissatisfied. Their poor sucking reflexes make it difficult for them to get enough nourishment, which leads to frustration for the baby and the caregivers/parents. Proper nourishment is especially important because of their low birth weights.

Fortunately, there are caregiving strategies that sometimes help to lessen the baby's distress.

[redacted] OR FEEDING AND SUCKING REFLEX:

- To help the baby focus, feed in a dark, quiet room without rocking or talking.
- Swaddling the child in a blanket may help calm them down to feed adequately.
- Feed these infants as soon as they show signs of being hungry. Some babies need smaller amounts every two hours.
- Ensure the bottle nipple is placed on top of the infant's tongue and there are no blockages in the nipple hole. Try nipples of different shapes to find the one that works best.
- To increase the baby's sucking ability, support the chin and cheeks.
- When spoon feeding, use a soft spoon and move it slowly and gently.
- Spitting up after feeding is especially common for babies with FAS. Be sure to burp the child frequently and place upright in an infant seat after a feeding.

If infant is frantically sucking his/her fists:

- Try to feed the baby to see if hunger is the problem.
- Try to burp the baby to ease possible abdominal discomfort.
- Use clothing with sewn-in mitts or cover hands with toddler socks to prevent damage to the skin on their hands. If skin does become irritated, keep the affected area clean with mild soap and water.
- Keep the baby's fingernails trimmed.

[redacted] E ON
DLING:

aby's arms flexed close
t and comfortably
de a soft blanket.
hould be bent towards
ach and also wrapped
ket. Never swaddle a
as a fever or seems
uble breathing.

[redacted] STIFFNESS, HYPERACTIVITY, TREMBLING, PROLONGED CRYING OR INABILITY TO SLEEP:

- Soothe the baby by holding snugly. If the child is too active to hold snugly, try swaddling in a soft blanket.
- Reduce external stimulation (e.g., loud noises, bright lights).
- Speak softly or try quiet music or singing.
- Soft humming or vertical rocking may be soothing.
- A soft, gentle massage may alleviate distress.
- Wait until the baby is alert and responsive to introduce something new.
- Use a mobile or music only if the baby has become able to tolerate it.
- Use frequent warm water baths if the baby enjoys the water. Applying baby oil will prevent the child's skin from drying.
- Because sucking is soothing for babies, help the child find their thumb or use a pacifier (with parent's permission). Do not place anything sweet, like honey, on the pacifier and never leave the child alone with a bottle. Both practices may cause tooth decay.
- Any movement that provides gentle vibration such as walking, riding in a car or swinging in a baby swing may be helpful. The accompanying low, humming sound is also soothing.
- For sleep times, wrap the baby snugly in a blanket and place the child in a quiet area with low light. A rocking cradle may be useful.
- Use a bedtime and naptime routine. Put the child to sleep in the same place and follow the same sequence of events (e.g. feeding, bathing, pajamas, into bed).
- Use background noise (e.g., a fan or gentle music) to help drown out other stimulating noise.
- When the baby starts to wake, gently rock the crib or rub the child's back. This will either help the child get back to sleep or assist with the transition of wakening.

A NOTE ON VERTICAL ROCKI[redacted]

Some babies affected by a[redacted] prefer up-and-down rocking[redacted] side-to-side motion. While[redacted] the baby close to you, gen[redacted] slowly rock them up and d[redacted] making eye contact seems[redacted] the baby fussy, try to have[redacted] facing outward while you r[redacted]

[redacted]GESTIONS:

- Always use slow and gentle movements to avoid startling the baby. Infants affected by alcohol usually need extra time to get used to interactions with caregivers.
- Swaddling, as previously described, helps provide security for a fidgety or floppy baby.
- When picking up the infant, get in the habit of telling the child in a quiet voice that you will be picking them up. After rubbing the baby's feet or back to ensure that he/she is calm and ready, you can pick the child up. Be particularly careful about supporting the head and holding the baby close to you. Using the same routine every time you pick up the baby will help him/her get used to it.
- Sometimes these babies become distressed or overstimulated when someone looks them in the eye. If this is the case, avoid face-to-face interactions by holding the baby facing outward. Work on the child's ability to make eye contact by turning the baby towards your face a little more each day.
- Use a baby carrier, backpack or sling if the child seems to be soothed by this type of holding.
- Before attempting a diaper change, try to calm the baby, or change the diaper after feeding when babies are often relaxed. Again, use slow movements and speak quietly to help prepare the baby. Stop after each step in the process to be sure the baby is ready to move on.
- Because feeding can often take a long time, be sure you are comfortable and relaxed.
- As babies affected by alcohol get older and start to move around, they may be less coordinated and have more accidents than other infants. As a result, extra effort should be made to baby-proof the environment (e.g. padding around any sharp corners).

[redacted]

[redacted]E ON ILLNESS [redacted]NTION:

[redacted]ected by alcohol [redacted] have weakened immune [redacted]naking them prone to [redacted]refore, special care [redacted]aken not to expose [redacted]o environmental irritants [redacted] and to avoid contact [redacted] who are sick.

When Children with FAS are in a Child Care Program

It's becoming increasingly common for young children to attend early childhood programs. These include full-time and part-time child care centres and family child care homes, as well as nursery schools and before-and-after school programs. Sometimes parents send their children to these programs while they are away at work or school. Sometimes children are enrolled for the social experience of being with peers and learning to get along with others.

The early childhood environment can be a place where developmental delays and social interaction issues become apparent. Caregivers may recognize when an individual child is having difficulties and suggest a referral to medical professionals for appropriate diagnosis.

For a child diagnosed with FAS, an early childhood program offers two types of benefits. One is that a child may make developmental gains as a result of the enriched experiences of the pre-school environment. The second benefit is such a program provides much needed respite for the parents.

Parents and early childhood educators or family child care providers are in a unique partnership when it comes to working with a child affected by alcohol. To provide the consistency that's so important to the child, parents and caregivers must work closely with, and be very supportive of one another. By sharing strategies, parents and caregivers can help each other interact more effectively with the child. Of course, the child will benefit from the consistent routines and smooth transitions created both at home and in the child care program.

[redacted] Starts the Early Childhood Program - The First Connection:

Parents of a child with FAS are the experts regarding the child's strengths and skills. Early Childhood Educators should access this knowledge to promote the child's development. Understanding that the parents are the most valuable contributors to the child's success is an important perspective for caregivers to have. Parents should receive a warm welcome and be made to feel that their input is respected and wanted.

Furthermore, all caregivers who will be working with a child affected by alcohol should understand the syndrome's neurological nature. In other words, caregivers need to remember

INFORMATION GATHERING:

When parents and caregivers first meet, the following issues should be discussed:

General Information:

- What does the caregiver need to know about the child (e.g., health problems, medications)?
- What are the parents' developmental goals for the child?

Communication Adaptations:

- What strategies have t found useful in working child?
- Does the child receive a services from a speech-pathologist, occupation pist, physiotherapist, c or other specialist?
- Has the child attended early childhood program

Behaviour:

- What are the child's cha and how will these affec child care experience?
- What are the child's int favourite activities or h
- What causes the child t overloaded?
- What should be said to children who ask about differences?

that the child's behaviour is not a result of poor parenting or a bad environment, but rather, of the brain damage that characterizes FAS.

The Early Childhood Educators will need the parents' cooperation and input. When a child enters a child care program, parents should make a point of telling the staff or care provider about what works at home. The more the caregivers know about the child's behaviour, their likes and dislikes, and usual routine, the better. This information can help caregivers make some aspects of the child care experience consistent with the child's home routine, thus preventing potential problems. Staff should focus on the child's abilities and strengths, rather than on the problems. A positive attitude can go a long way. Parents should also share relevant information and professional reports on the child with the caregiver staff. This helps the staff better understand the child's unique needs and goals.

[redacted] Communication:

Once the child enters the child care program, there should be a process in place to ensure regular sharing of information between the parent and the staff. Ideally, they should be communicating on a daily basis.

A *communication book* - Some type of notebook in which parents and caregivers write details about the child — is most commonly used. For instance, the caregiver might write down what the child ate at the program, whether they napped, what activities they participated in, and things about the day that went particularly well. Parents might include details about the child's time at home, especially how the child spent the time before coming to the centre or family day care home. Writing these details down as they happen, rather than relying on one's memory, is a much more reliable method of communication. Things can be hectic as children come and go from the program, making it difficult for parents and caregivers to adequately fill each other in during these times.

The communication book becomes especially important for goal setting as well as establishing and maintaining consistent routines. Parents and caregivers can communicate how things are going in the book, as well as share tips on what seems to be working well. It's not always easy coordinating a time to discuss these things face-to-face or even on the phone. Therefore, it's helpful to have the details in the book to refer to when these encounters do take place.

Regular team meetings are also important. They should include everyone involved with the child (e.g. parents, professionals providing services to the child and/or family, caregivers who work most closely with the child, and the centre director or family day care provider. These meetings can be used to assess a child's progress, establish new goals and discuss intervention strategies. Each member of the team will have a unique perspective that will add to the overall picture of how to best support the child.

The person leading the meeting should use an organized approach to ensure that everyone's input is given. It is useful to start with an agenda or a list of topic areas relevant to the child being discussed. Some examples are:

- social development - ability to take turns, interact with others and tolerate frustration
- attending - ability to focus, complete a task and follow directions
- communication - ability to understand language, express thoughts and respond appropriately to cues
- cognitive development - targeted concepts (e.g. shapes, colours, numbers)
- activities of daily living - dressing, toileting, eating and sleeping routines

For each area, the team should discuss the child's progress and the strategies being used. As goals are met, new ones should be set. If goals are not being met, the team should consider why not, as well as discussing new strategies that could be tried.

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tion:

ports, or other informa-
ut the child should be
vith the program?

areas has the child
ced particular success?

areas would the
particularly like the
succeed?

and Child Care
m Connection:

any additional
tion the centre should
out the child (e.g., recent
, history of living
ments, if adopted or
care)?

a consistent approach
the home and the child
gram be maintained?

- Does the parent have any questions about the program?

Services for Children with FAS

A child's individual needs will determine which types of services to access in order to support their development. Usually, the professionals involved will consult on the child's progress and participate in establishing goals. Some of the professionals who may be involved with an alcohol-affected child are listed below, along with each person's typical role.

Special Needs Worker: When a child diagnosed with FAS enters a child care program, there may be funding in place for a Special Needs Worker to work with the child. This funding may cover part or all of the time the child attends the program. Ideally, the Special Needs Worker has training in child development as well as advanced training and experience in the area of integrating children with special needs.

It's the role of the Special Needs Worker to assess the child's ability to function within the program and make appropriate accommodations. Usually, the additional support provided by the Special Needs Worker allows the child to be included successfully in most or all of the daily routines at the centre. Even though the Special Needs Worker is hired to help a particular child or children meet their goals, they generally work with the child in the larger group, rather than removing the child for one-on-one instruction.

The Special Needs Worker works closely with parents and other professionals to help the child develop new skills and encourage them to participate in the child care program. The Special Needs Worker should also be a participating member of the child care team, soliciting feedback from co-workers and relaying to them the strategies needed to facilitate the child's integration. Considering the importance of environmental modifications when working with an alcohol-affected child, the Special Needs Worker may need to help other ECEs understand how certain program changes will benefit the special-needs child and may also be helpful for other children with challenging behaviours.

Occupational Therapist (O.T.): One of the roles of an Occupational Therapist is to assess an individual's physical and sensory needs. Because children with FAS commonly have problems processing sensory information and using motor skills, a referral to an O.T. is often made. The O.T. can set up a program to address the difficulties the child is having with fine and gross motor development, activities of daily living, sensory processing and proprioception. (This refers to a person's awareness of his or her own body position - i.e. where one's body parts are in space).

The O.T. can suggest environmental adaptations to accommodate the child's unique needs. A multi-sensory approach is often used, incorporating movement, music and various sensory modalities. A child may be put on a "sensory diet" which refers to a controlled program of sensory input designed to suit the needs of a particular child.

Increasing the child's ability to pay attention and to remain calm is often a focus of the O.T.'s work.

Speech Language Pathologist (SLP): Children with FAS commonly experience a wide range of speech and language difficulties. There may be articulation difficulties, limited vocabulary, inappropriate use of language, difficulties with the rate of speech, poor receptive language and excessive talking. Early assessment, diagnosis and treatment by a SLP are important.

The SLP's therapeutic plan will, of course, depend on the nature of the problem. Often the SLP will provide direct treatment, as well as consult with and guide the family in working on the child's speech and language. When the child attends a child care program, the SLP often consults with staff to involve them in the intervention. In fact, placement in a preschool program may be recommended to help the child develop language skills, especially when there is the opportunity for one-on-one teaching and the repetition of information.

Physiotherapist: Physiotherapists can be involved with any person experiencing a gross motor problem. However, when a physiotherapist sees children with FAS, it tends to be for difficulties with balance and posture. Since these problems occur for just a small percentage of children affected by alcohol, a physiotherapist is often not involved in their treatment. When physiotherapy is necessary, the child is usually assessed in the home or child care setting. The physiotherapist provides the parents and/or early childhood educators with a program of activities and exercises and then monitors the child's progress.

Preschool Developmental Specialists: Birth, foster, adoptive or extended families of children diagnosed with FAS can access Preschool Developmental Specialists through the FAS Outreach Team of Children's Special Services (a diagnosis is required). The services these specialists provide include developmental and behavioral consultations of children with FAS as well as education or inservicing for people living or working with children affected by alcohol. The Preschool Developmental Specialist provides guidance to the family, as well as to the staff of any child care program the child attends.

Typically, visits are made either to the home or child care program. The Preschool Developmental Specialist reviews and monitors the child's progress and recommends intervention techniques. As well, they usually model these techniques for the parents and caregivers. The Preschool Developmental Specialist plays an important role in helping parents and caregivers understand how children affected by alcohol best learn, and why they respond as they do. This understanding helps the caregivers to have appropriate expectations, increased patience and more effective interactions with the child.

Appendix

I. **Fetal Alcohol Syndrome (FAS) with Confirmed Maternal Alcohol Exposure** - For a child to be diagnosed in this category, there must be a known history of prenatal exposure to alcohol and the following three characteristics:

   Delayed growth - usually in the smallest 10%.

   Distinct facial features - including short eye openings, drooping eyelids, wide-set eyes and folds of skin on inner corner of eyes; flattened nose and upper lip; flattened cheek area; thin upper lip; and small lower jaw. These are most noticeable during childhood.

   Central nervous system dysfunction - could include small head circumference (below the third percentile), developmental delay and/or intellectual disabilities.

II. **FAS without Confirmed Maternal Alcohol Exposure** - This category applies to a child who exhibits the characteristics listed above without definite knowledge of the mother's alcohol use during pregnancy.

III. **Partial FAS with Confirmed Maternal Alcohol Exposure** - This refers to a child for whom there is a known history of prenatal alcohol exposure and some of the characteristic facial features, along with either delayed growth or central nervous system dysfunction (as described above) or a complex pattern of behavioural or cognitive difficulties not related to developmental level, family background or environment alone. This could include learning problems, social problems, poor school performance or impulse control, language difficulties and trouble with abstract reasoning, memory, attention or judgment.

   The next two categories require confirmed maternal alcohol exposure. They can occur together or independently and they refer to very specific outcomes of prenatal alcohol exposure.

IV. **Alcohol-Related Birth Defects (ARBD)** - This refers to a wide variety of congenital defects affecting the heart, skeleton, kidneys, vision and/or hearing.

V. **Alcohol-Related Neurodevelopmental Disorder (ARND)** This refers to a child with central nervous system dysfunction (as described above) and/or a complex pattern of behaviour or cognitive difficulties (as described above).

SOURCE: Institute of Medicine (IOM), Stratton, K.R., Howe, C.J., & Battaglia, F.C. (Eds.). (1996). *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention and Treatment.* Washington, DC: National Academy Press. In: Streissguth, A.P., (1997), *Fetal Alcohol Syndrome: A Guide for Families and Communities.* Baltimore: Paul H. Brookes Publishing Co.

Resources

Some of the resources, programs and organizations listed have contributed information included in this manual.

Clinic for Alcohol and Drug Exposed Children
Children's Hospital of Winnipeg
CK253-840 Sherbrook Street
Winnipeg, MB R3A 1S1
Phone: (204) 787-1828
Fax: (204) 787-1138

Fetal Alcohol Support Team
FAS Tele-Diagnostic Clinic
Thompson General Hospital
871 Thompson Drive South
Thompson, MB R8N 0C8
Phone (204) 677-5314
Fax: (204) 677-5339

Child Development Clinic
Children's Hospital of Winnipeg
CK253-840 Sherbrook Street
Winnipeg, MB R3A 1S1
Phone: (204) 787-2424
Fax: (204) 787-1138

Child and Adolescent Mental Health Centre
PsycHealth Centre, Health Sciences Centre
771 Bannatyne Avenue
Winnipeg, MB R3E 3N4
Phone: (204) 787-3873
Fax: (204) 787-4975

Clinical Health Psychology
PsycHealth Centre, Health Sciences Centre
771 Bannatyne Avenue
Winnipeg, MB R3E 3N4
Phone: (204) 787-7469
Fax: (204) 787-4975

Child and Adolescent Mental Health Program
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, MB R2H 2A6
Phone: (204) 237-2690
Fax: (204) 233-8051

Manitoba Adolescent Treatment Centre
Clinical Services for Children and Youth
- Hospital Program
120 Tecumseh Street
Winnipeg, MB R3E 2A9
Phone: (204) 477-6391
Fax: (204) 783-8948

Manitoba Adolescent Treatment Centre
Clinical Services for Children and Youth
- Community Services Program
228 Maryland Street
Winnipeg, MB R3G 1L6
Phone: (204) 958-9600
Fax: (204) 958-9618

For areas outside urban centres:

Contact Mental Health Services
at the local Regional Health Authority office
or call:
Regional Support Service
Phone: (204) 786-7255
Web Site: www.gov.mb.ca/health/index/html

[redacted]

Aboriginal Health & Wellness Centre of Winnipeg, Inc.
FAS/FAE Prevention Program
215- 181 Higgins Avenue
Winnipeg, MB R3B 3G1
Phone: (204) 925-3700
Fax: (204) 925-3709

Children's Special Services
Directorate
201-114 Garry Street
Winnipeg, MB R3C 4V5
Phone: (204) 945-6717
Fax: (204) 948-2669

FAS/FAE Outreach Team
Unit 3-139 Tuxedo Avenue
Winnipeg, MB R3N 0H6
Phone: (204) 945-8137
Fax: (204) 948-1735

Interagency FAS/FAE Program
49-476 King Street
Winnipeg, MB R2W 3Z5
Phone: (204) 582-8658
Fax: (204) 586-1874

Macdonald Youth Services
175 Mayfair Avenue
Winnipeg, MB R3L 0A1
Phone: (204) 477-1722
Fax: (204) 284-4431

Nor'West Mentor Program
103-61 Tyndall Avenue
Winnipeg, MB R2X 2T1
Phone: (204) 632-8162
Fax: (204) 632-4666

Oski-Keesekow Project
P.O. Box 250
Norway House, MB R0B 1B0
Phone: (204) 359-6968
Fax: (204) 359-6011

Rehab Centre for Children
633 Wellington Crescent
Winnipeg, MB R3M 0A8
Phone: (204) 452-4311
Fax: (204) 477-5547

Society for Manitobans with Disabilities
825 Sherbrook Street
Winnipeg, MB R3A 1M5
Phone: (204) 975-3010
Fax: (204) 975-3073

St. Amant Centre Inc.
440 River Road
Winnipeg, MB R2M 3Z9
Phone: (204) 256-4301
Fax: (204) 257-4349

Fetal Alcohol Family Association of Manitoba
210-500 Portage Avenue
Winnipeg, MB R3C 3X1
Phone: (204) 786-1847
Fax: (204) 789-9850

New Directions for Children, Youth and Families
- Support Group for Parents
400- 491 Portage Avenue
Winnipeg, MB R3B 2E4
Phone: (204) 786-7051 ext. 303
Fax: (204) 772-7069

FAS/FAE Resource and Information Centre
Addictions Foundation of Manitoba
1031 Portage Avenue
Winnipeg, MB R3G 0R8
Phone: (204) 944-6361
Fax: (204) 772-0225

William Potoroka Memorial Library
Addictions Foundation of Manitoba
1031 Portage Avenue
Winnipeg, MB R3G 0R3
Phone: (204) 944-6277
Fax: (204) 772-0225

Canadian Centre on Substance Abuse
FAS/FAE Information Service
1-800-559-4514
www.ccsa.ca/fasgen.htm
List of FAS Sites - www.ccsa.ca/classed1.htm#fas

Association for Community Living - Manitoba
210-500 Portage Avenue
Winnipeg, MB R3C 3X1
Phone: (204) 786-1607
Fax: (204) 789-9850

Canada Prenatal Nutrition Program
Manitoba Region
300-391 York Avenue
Winnipeg, MB R3C 4W1
Phone: (204) 983-3637
Fax: (204) 984-7458

CAPC/CPNP Regional Programs
420-391 York Avenue
Winnipeg, MB R3C 0P4
Phone: (204) 983-7690
Fax: (204) 983-8674

Coalition on Alcohol and Pregnancy
1031 Portage Avenue
Winnipeg, MB R3G 0R8
Phone: (204) 944-6358

Manitoba Child Care Association
364 McGregor Street
Winnipeg, MB R2W 4X3
Phone: (204) 586-8587
or 1-888-323-4676
Fax: (204) 589-5613

Manitoba Healthy Child Initiative
100-233 Portage Avenue
Winnipeg, MB R3B 2A7
Phone: (204) 945-2266
Fax: (204) 948-2585

Chemical Withdrawal Unit, Health Sciences Centre
GB2-820 Sherbrook Street
Winnipeg, MB R3A 1R9
Phone: (204) 787-3855
Fax: (204) 787-5002, Attention: "2B"

Laurel Centre
62 Sherbrook Street
Winnipeg, MB R3C 2B3
Phone: (204) 783-5460
Fax: (204) 774-2912

Native Addictions Council of Manitoba
160 Salter Street
Winnipeg, MB R2W 4K1
Phone: (204) 586-8395
Fax: (204) 589-3921

Native Women's Transition Centre
105 Aikins Street
Winnipeg, MB R2W 4E4
Phone: (204) 989-8240
Fax: (204) 586-1101

Nelson House Medicine Lodge
General Delivery
Nelson House, MB R0B 1A0
Phone: (204) 484-2256
Fax: (204) 484-2016

Parkwood
510 Frederick Street
Brandon, MB R7A 6Z4
Phone: (204) 729-3838
Fax: (204) 727-1610

Peguis Al-Care Treatment Centre
Box 69
Peguis, MB R0C 3J0
Phone: (204) 645-2666
Fax: (204) 645-2216

Polaris Place
23 Nickel Road
Thompson, MB R8N 0Y4
Phone: (204) 677-7300
Fax: (204) 677-7328

River House
588 River Avenue
Winnipeg, MB R3L 0E8
Phone: (204) 944-6229
Fax: (204) 284-5520

Rosaire House
Box 240
The Pas, MB R9A 1K4
Phone: (204) 623-6425
Fax: (204) 623-4475

St. Norbert Foundation
3514 Pembina Highway
Winnipeg, MB R3V 1M6
Phone: (204) 269-3430
Fax: (204) 269-8049

Salvation Army Women's Services
180 Henry Avenue
Winnipeg, MB R3B 0J8
Phone: (204) 946-9461
Fax: (204) 943-8898

Tamarack Rehab Inc.
60 Balmoral Street
Winnipeg, MB R3C 1X4
Phone: (204) 772-9836
Fax: (204) 772-9908

Virginia Fontaine Memorial Centre Inc.
Box 5
Fort Alexander, MB R0E 0P0
Phone: (204) 367-4053
Fax: (204) 367-2831

Willard Monson House
Box 490
Ste. Rose du Lac, MB R0L 1S0
Phone: (204) 447-4040
Fax: (204) 447-4050

Whiskey Jack Treatment Centre
336 Thompson Drive
Thompson, MB R8N 0C4
Phone: (204) 778-5120
Fax: (204) 778-5131

The B.C. FAS Resource Society Newsletter
Sunny Hill Centre for Children
3644 Slocan Street,
Vancouver, B.C., V5M 3E8

FANN: Fetal Alcohol Network News
158 Rosemont Avenue,
Coatesville, PA 19320-3727

F.A.S. Times - FAS Family Resource Institute
PO Box 2525,
Lynnwood, WA 98036
Telephone: (253) 531-2878

F.A.S. Track
P.O. Box 3418,
Peoria, IL 61612
Telephone: (309) 691-3800
FAS/E Nation- B.C. FAS Resource Society
B.C. FAS Resource Society, 3644
Slocan Street, Vancouver, B.C. V5M 3E8
Telephone: (604) 589-1854 Fax: (604) 589-8438

FASLINK
On-line message board. To join the list, send an e-mail message to majordomo@listserv.rivernet.net and type: subscribe faslink (in lower case letters) in the body of the message.

The FEN Pen - Family Empowerment Network
FEN, University of Wisconsin-Madison, 521 Lowell Hall, 610 Langdon Street, Madison, WI 53703-1195
Telephone: (608) 262-6590

Growing with FAS
7802 S.E. Taylor,
Portland, OR 97215

ICEBERG -
Fetal Alcohol Syndrome Information Services (FASIS)
PO Box 95597,
Seattle, WA 98145-2597.

Manitoba F.A.S. News -
The Coalition on Alcohol & Pregnancy (CAP)
c/o Association for Community Living
210-500 Portage Avenue,
Winnipeg, MB R3C 3X1
Telephone: (204) 786-1607

Notes from NOFAS - National Organization on Fetal Alcohol Syndrome (NOFAS)
1819 H Street NW, Suite 750,
Washington, D.C. 20006

SNAP - Society of Special Needs Adoptive Parents
409 Granville Street, Suite. 1150,
Vancouver, BC V6C 1T2
Telephone: (604) 687-3114

"Best FAS/FAE Links on the web":
www.zastarnet.com/~tjk/faslinks.htm

Fetal Alcohol Syndrome Community Resource Centre (home site): www.azstarnet.com/~tjk/fashome.htm

Canadian Centre on Substance Abuse (CCSA)
www.ccsa.ca/fasgen.htm

Alcohol Related Birth Injury (FAS/FAE) Resource Site:
www.arbi.org/

Fetal Alcohol and Drug Unit:
http://depts.washington.educ/fadu/

The Fetal Alcohol Support Network of Toronto & Peel:
www.acbr.com/fas/index.htm

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